Suicide in Children and Young People

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NCMD

National Child Mortality Database

Knowledge, understanding and learning to improve young lives

NCMD Thematic Report on Suicide in Children and Young People

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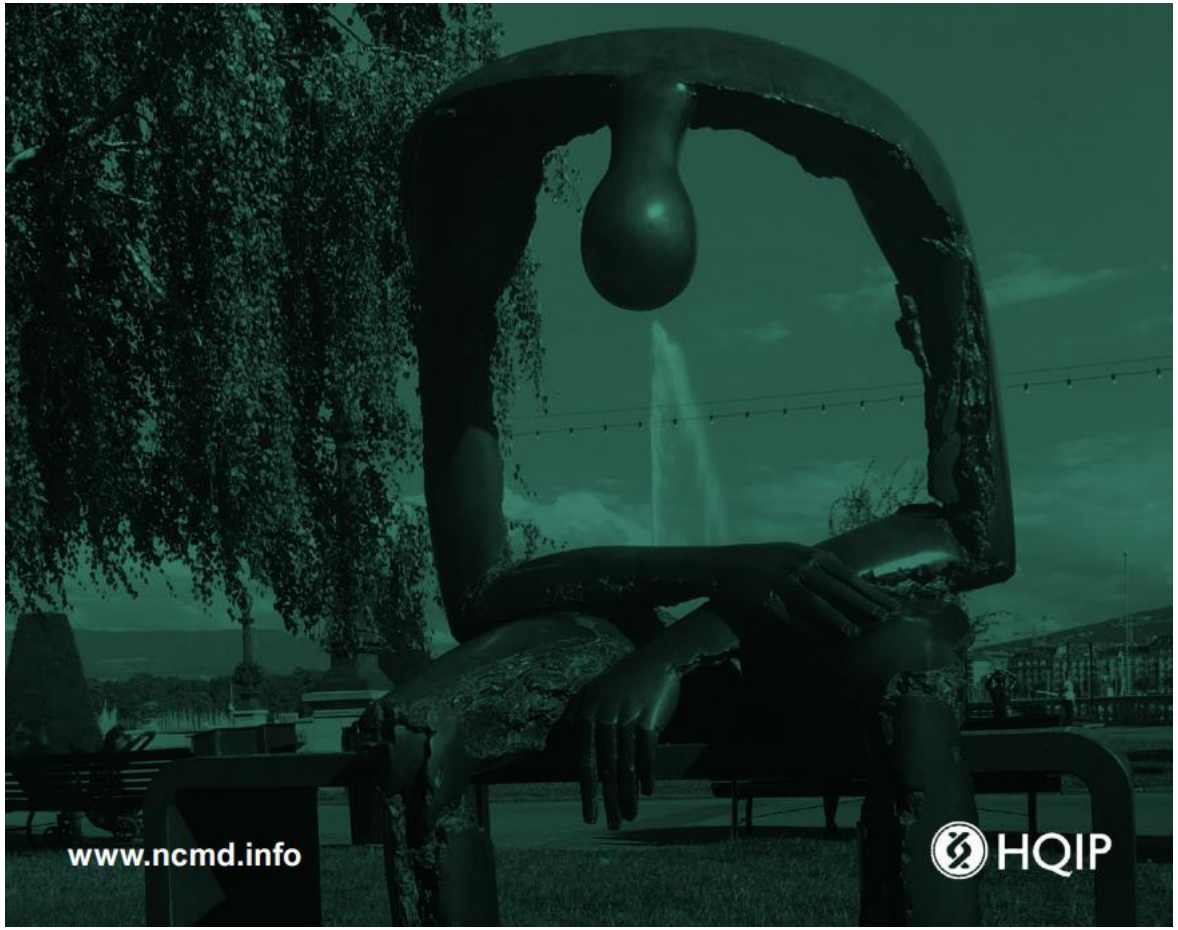


The National Child Mortality Database

- Commissioned by HQIP on behalf of NHS England
- Led by University of Bristol in collaboration with partners
- The Lullaby Trust, Sands and Child Bereavement UK are our partner charities
- Started collecting data on 1 April 2019

Our Aim

To collate and analyse information nationally to ensure that deaths are learned from, that learning is widely shared and that actions are taken, locally and nationally, to reduce the number of children who die.

Child Death Reviews

Child Death Overview Panels (CDOPs) are tasked with reviewing deaths of children resident in their area

There is a legal requirement to notify deaths to NCMD within 48 hours

Following this a comprehensive, multi-agency information gathering process is carried out

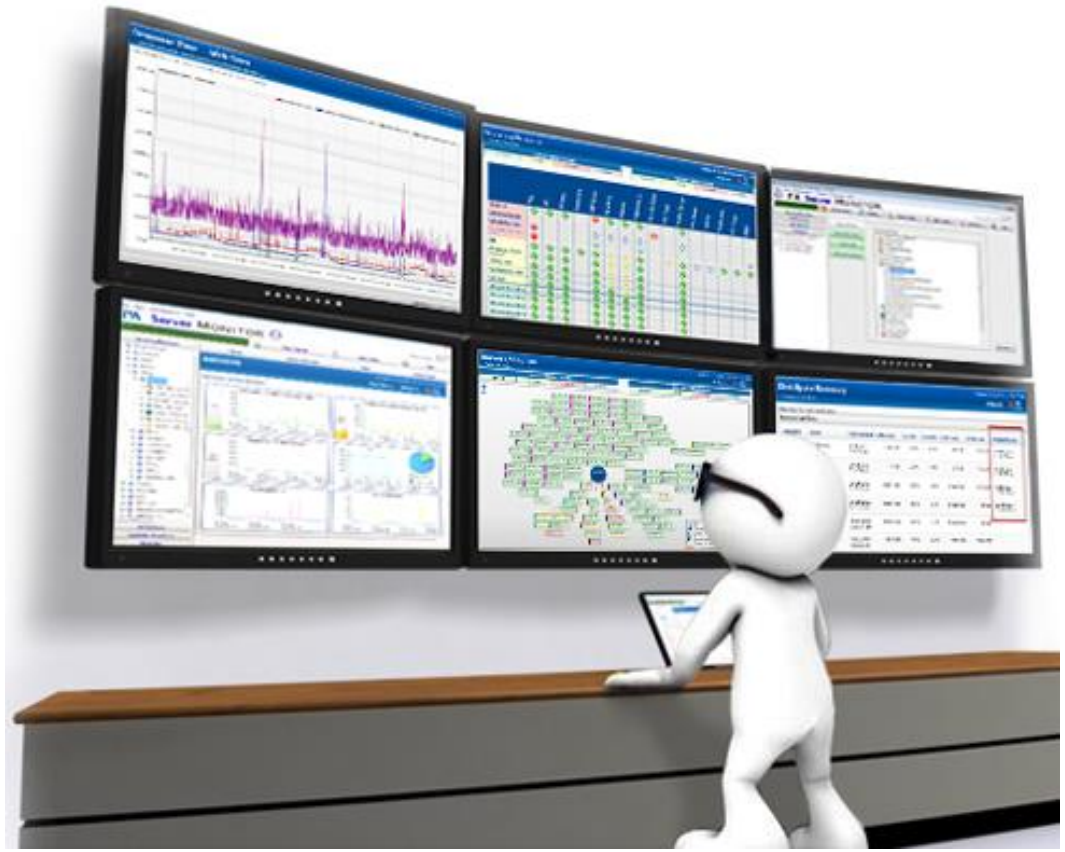
Information is collected on statutory forms and includes the views of families

NCMD Analysis

There are two ways in which data is analysed by NCMD. Real-time surveillance and analysis of reviewed data

Real-time surveillance includes data from the 48 hour notification

Analysis of reviewed data includes the full dataset after review by CDOP (often not available until many months after death)



Suicide in Children and Young People

"Suicide is complex, rarely caused by one thing, and suicide prevention is also complex. We need to understand who is at risk and when, the stresses and settings, and the response of services. We need to know the numbers – these are not dry data; they tell us the size of the prevention challenge and whether risk is changing."

Methodology

Data relating to two separate cohorts of children and young people

Notification Cohort: Children and young people who died between 1 April 2019 and 31 March 2020 and whose death was coded by the NCMD team as being **highly or moderately likely due to suicide**.

Review Cohort: Children and young people whose deaths were reviewed by a CDOP between 1 April 2019 and 31 March 2020 and classified by CDOP as Category 2* on the statutory analysis form, excluding those assessed as substance misuse related deaths. **The deaths of these children and young people occurred between 2015/16 and 2019/20**.

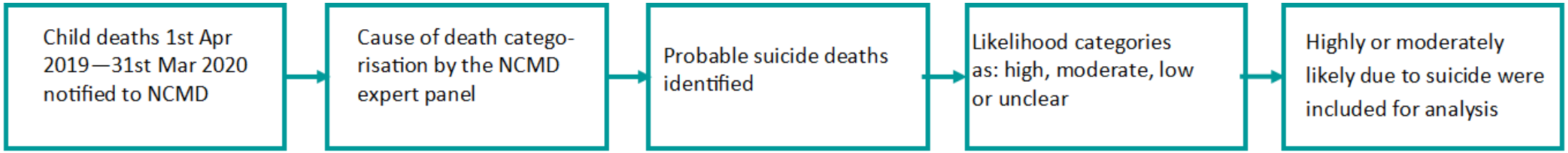
* Category 2 relates to deaths due to suicide or deliberate self-inflicted harm. This includes deaths as the result of hanging, shooting, self-poisoning with drugs, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm.

Methodology – Notification Cohort

Aim: To describe the characteristics of children and young people whose deaths are likely to have been due to suicide

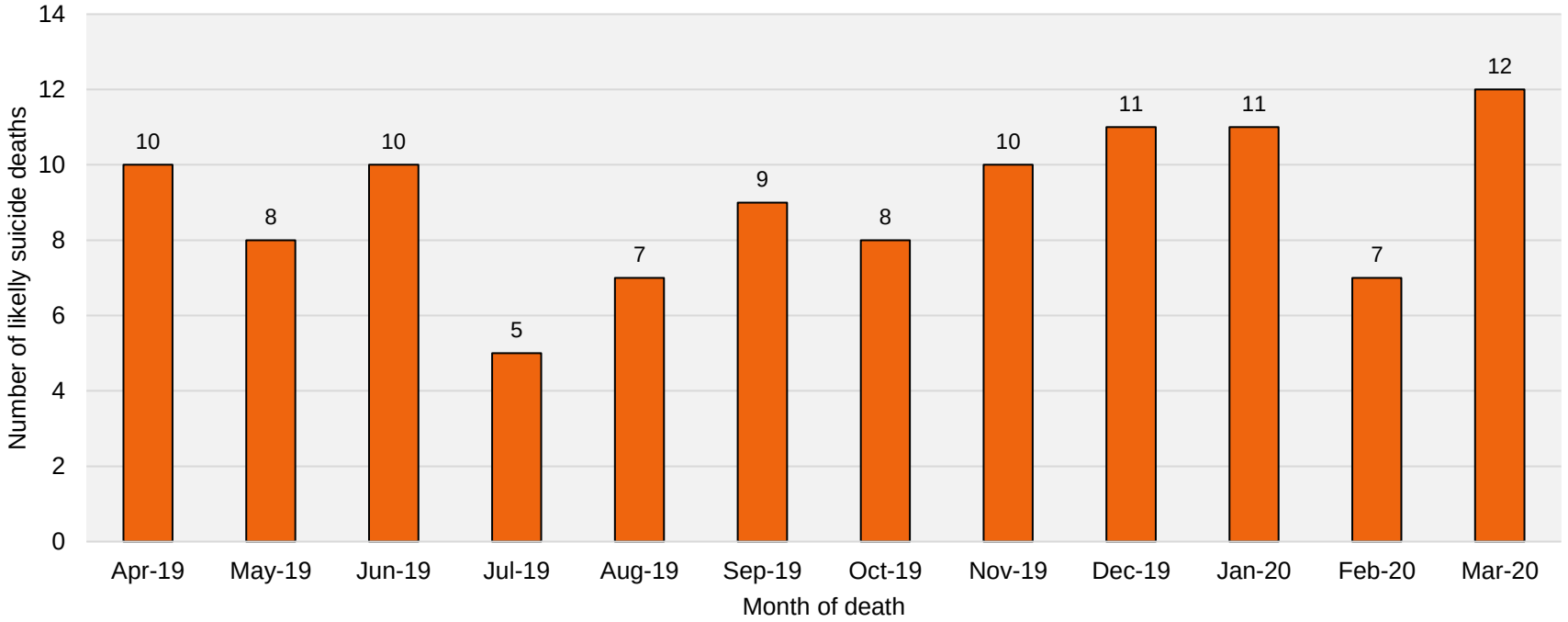
Data Source: The child death notification form, completed within 48 hours of the death occurring, usually by a Joint Agency Response (JAR) practitioner (paediatrician, nurse or health visitor) or a police officer. Includes information from discussions with the child or young person's family in the 48 hours following the death. Some deaths may subsequently be re-classified as due to something other than suicide once the full post-mortem, investigation and review process have been completed.

Categorisation:



Analysis: Rates of suicide derived by:
-2019 ONS estimated data by sex, age and region of residence for 9 to 17 years-old
-Negative binominal distribution model for statistical comparisons
-P-values using the likelihood ratio test

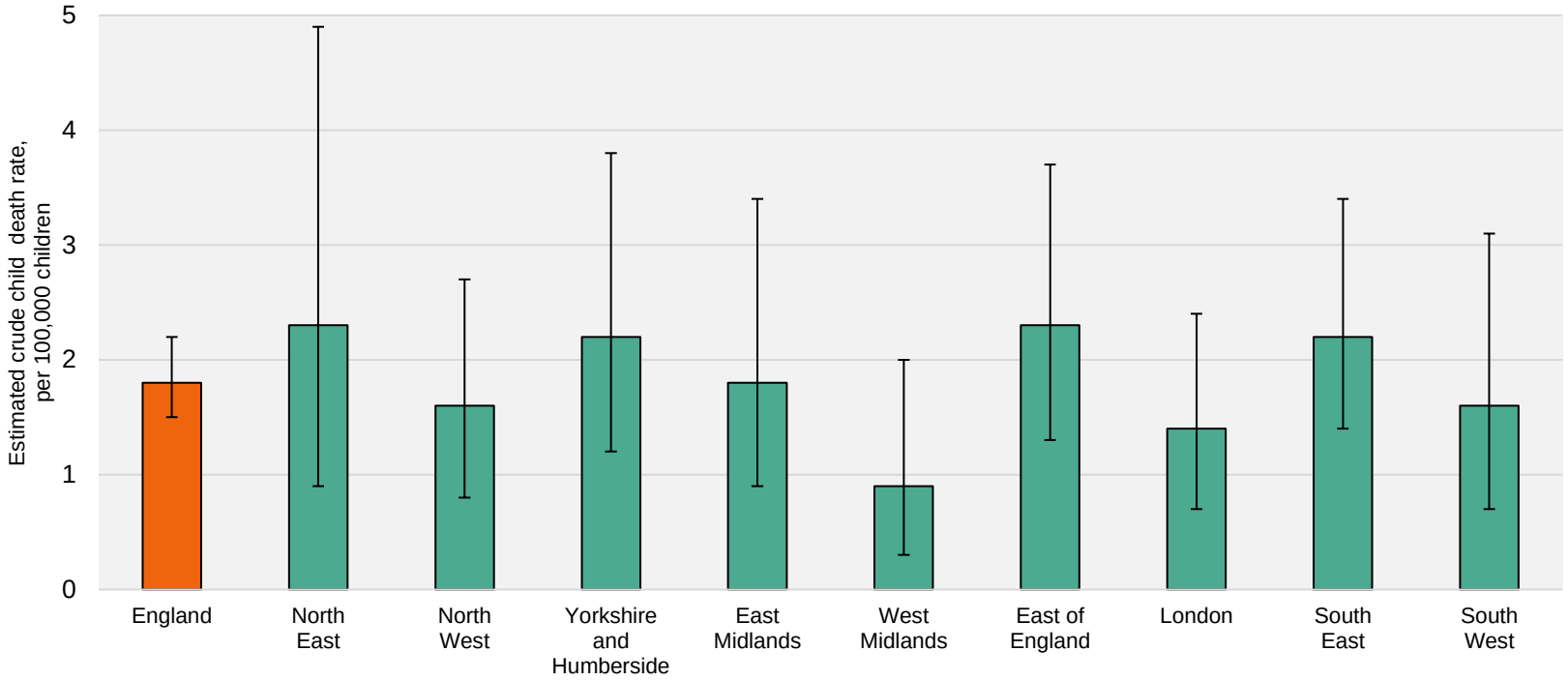
The number of child/young person death notifications received by CDOPs assessed as highly or moderately likely to be due to suicide by month, year ending 31 March 2020.



Total n=108

Data source NCMD

Rate of child/young person deaths assessed as highly or moderately likely to be due to suicide by region, year ending 31 March 2020.

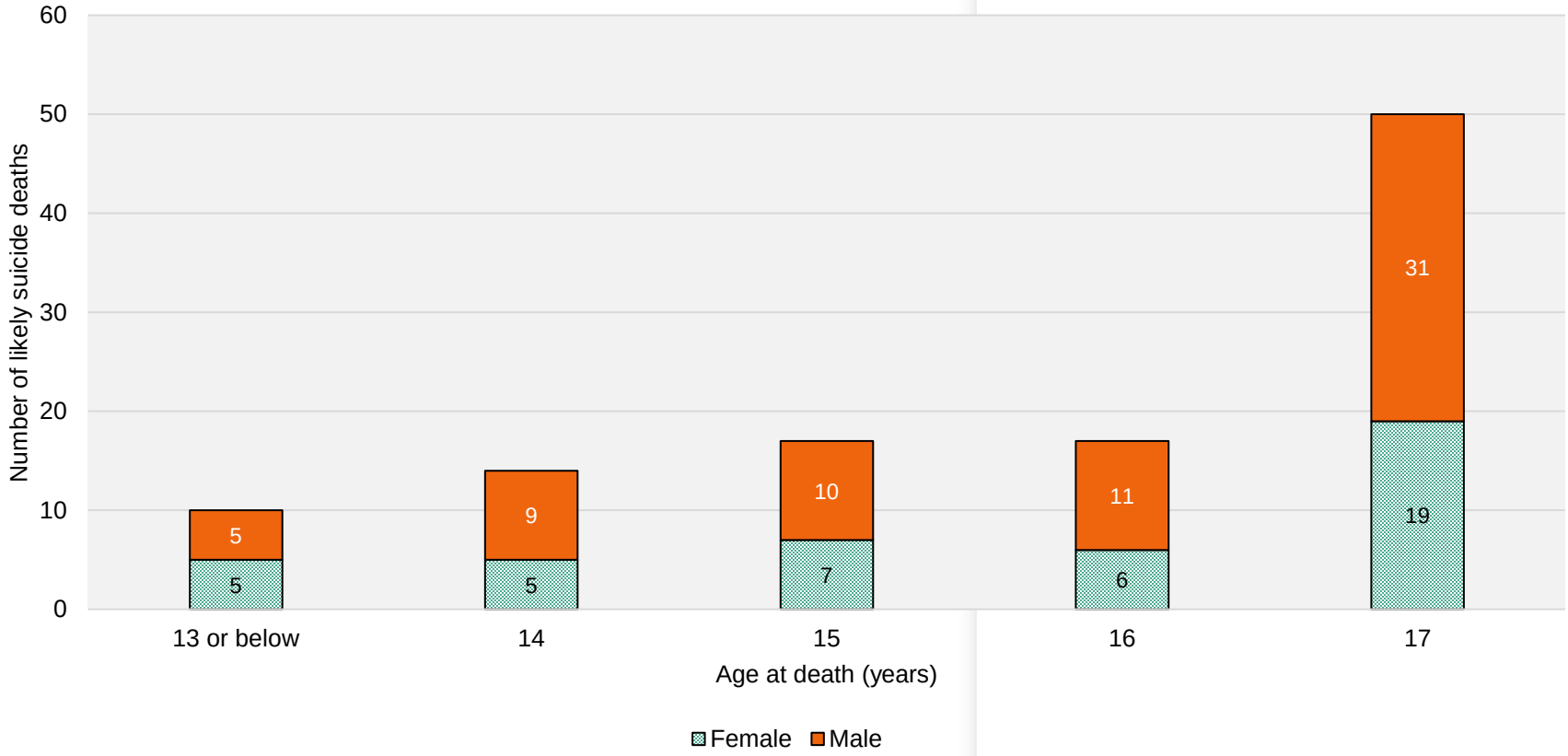


Data source: NCMD, 2019 mid-year population estimate (ONS)

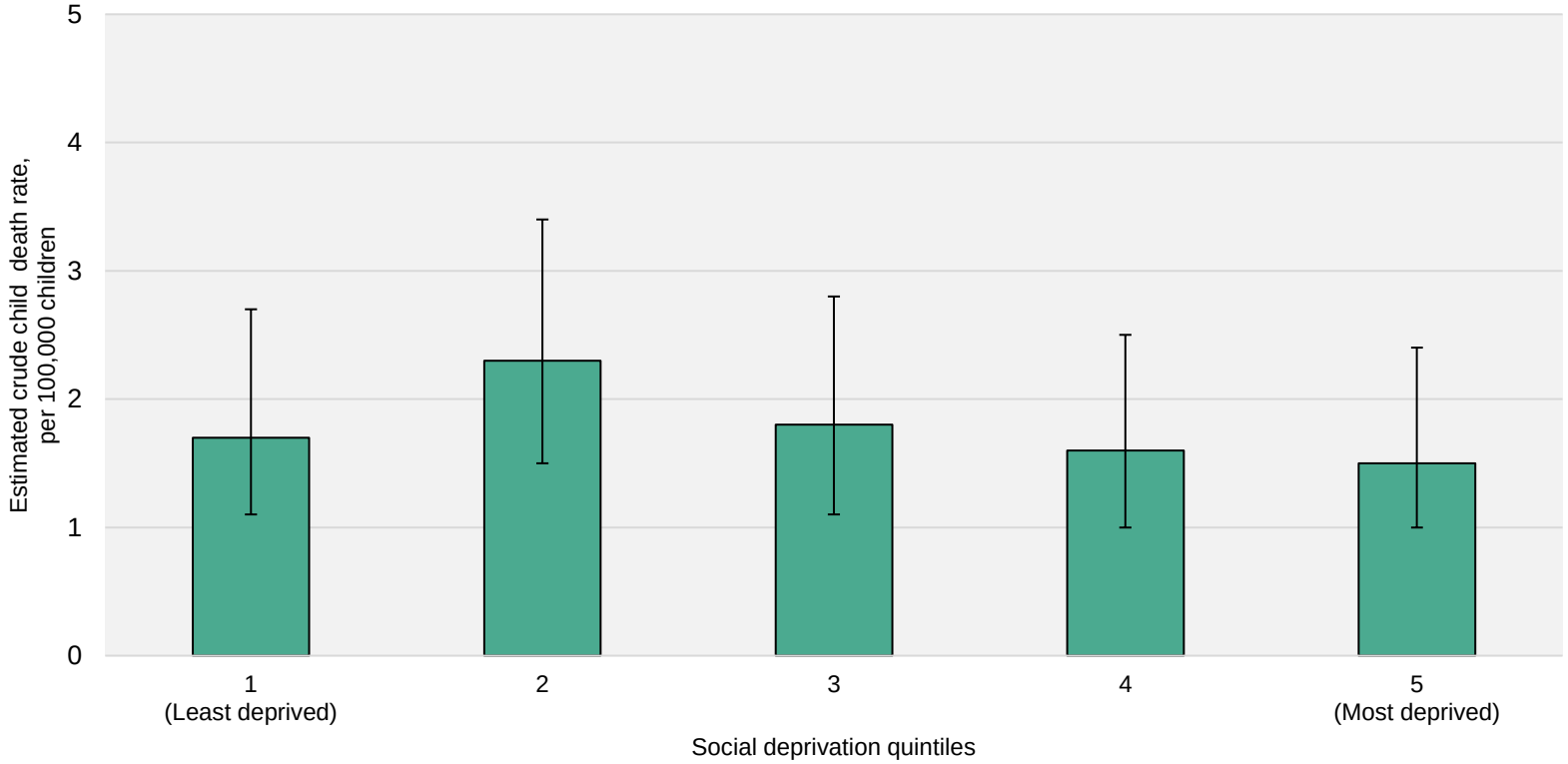
I represents 95% confidence intervals

In 3 instances postcode was not known or incomplete and data linkage to derive region was not possible

The number of deaths of children/young people assessed as highly or moderately likely to be due to suicide, by sex and age at death, year ending 31 March 2020.



The rate of child/young person deaths assessed as highly or moderately likely to be due to suicide and the estimated crude death rate by deprivation quintiles, year ending 31 March 2020



Data source: NCMD, IMD (2019)

I represents 95% confidence intervals

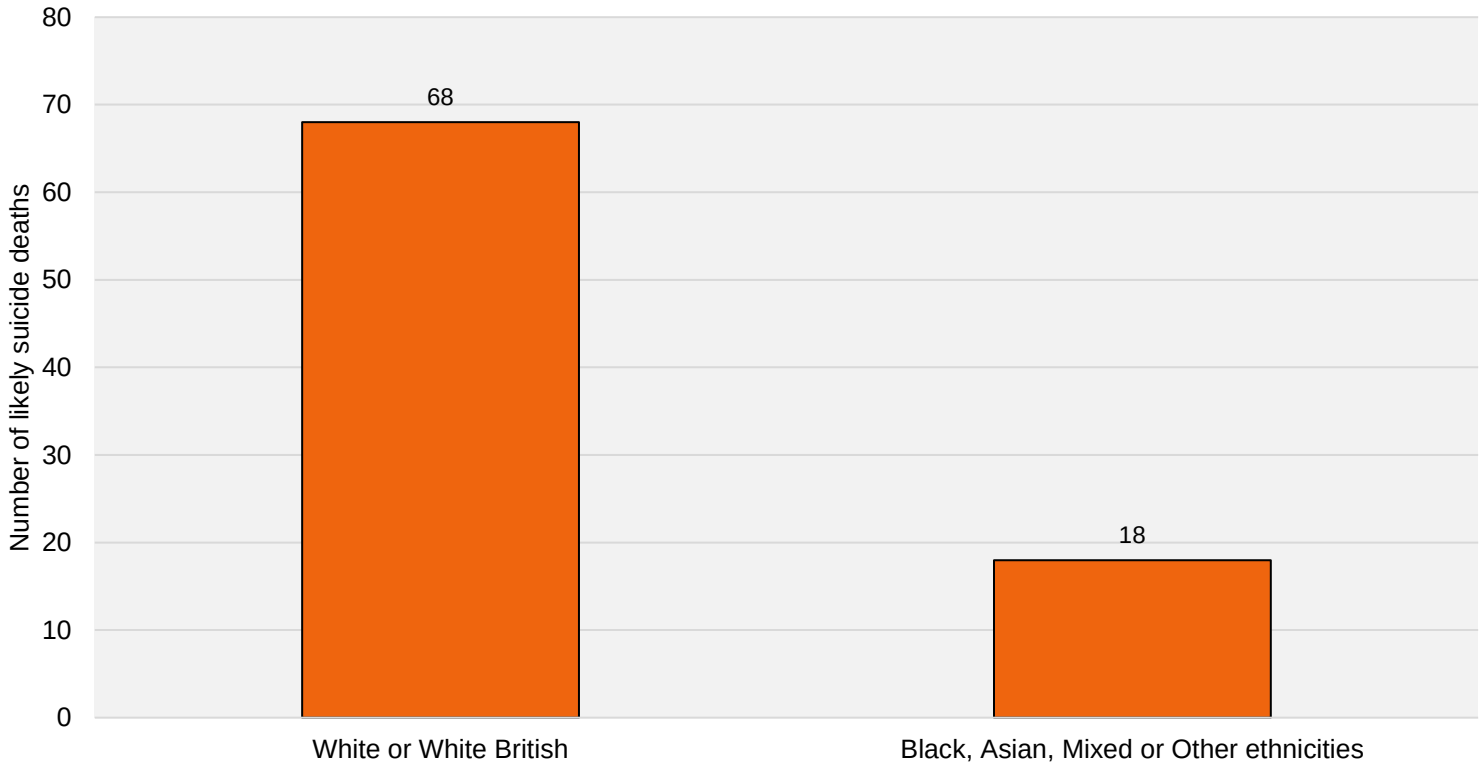
The postcode of each child or young person was linked to its corresponding Index of Multiple Deprivation (IMD 2019) which is an areas base measure of social deprivation calculated to the granularity of around 1,500 people. Each neighbourhood is ranked from most deprived to least deprived, which are then divided into five equal sized groups (quintiles).

NCMD National Child Mortality Database

The number and estimated rate of child/young person deaths assessed as being highly or moderately likely to be due to suicide by characteristic, year ending 31 March 2020.

	Number (%) of deaths	Estimated population (9 – 17 years)*	Estimated crude death rate, per 100,000 children/ young people (95% CI)	p-value
All likely suicide deaths	108 (100%)	5,886,033	1.8 (1.5-2.2)	
Age at death (years)				0.008
13 or below	10 (9%)	3,420,413	0.3 (0.1-0.5)	
14	14 (13%)	634,057	2.2 (1.2-3.7)	
15	17 (16%)	624,607	2.7 (1.6-4.4)	
16	17 (16%)	607,513	2.8 (1.6-4.5)	
17	50 (46%)	599,443	8.3 (6.2-11.0)	
Sex				0.042
Female	42 (39%)	2,867,247	1.5 (1.0-2.0)	
Male	66 (61%)	3,018,786	2.2 (1.7-2.8)	
Region^				0.524
North East	6 (6%)	265,152	2.3 (0.9-4.9)	
North West	12 (11%)	766,943	1.6 (0.8-2.7)	
Yorkshire and Humberside	13 (12%)	578,372	2.2 (1.2-3.8)	
East Midlands	9 (9%)	496,503	1.8 (0.9-3.4)	
West Midlands	6 (6%)	639,818	0.9 (0.3-2.0)	
East of England	15 (14%)	660,032	2.3 (1.3-3.7)	
London	13 (12%)	938,220	1.4 (0.7-2.4)	
South East	22 (21%)	985,645	2.2 (1.4-3.4)	
South West	9 (9%)	555,345	1.6 (0.7-3.1)	
Area^				0.920
Urban	88 (84%)	4,911,642	1.8 (1.4-2.2)	
Rural	17 (16%)	974,388	1.7 (1.0-2.8)	
Social deprivation quintile^				0.390
1 (Least deprived)	20 (19%)	1,161,657	1.7 (1.1-2.7)	
2	25 (24%)	1,084,237	2.3 (1.5-3.4)	
3	20 (19%)	1,101,612	1.8 (1.1-2.8)	
4	19 (18%)	1,179,815	1.6 (1.0-2.5)	
5 (Most deprived)	21 (20%)	1,358,709	1.5 (1.0-2.4)	

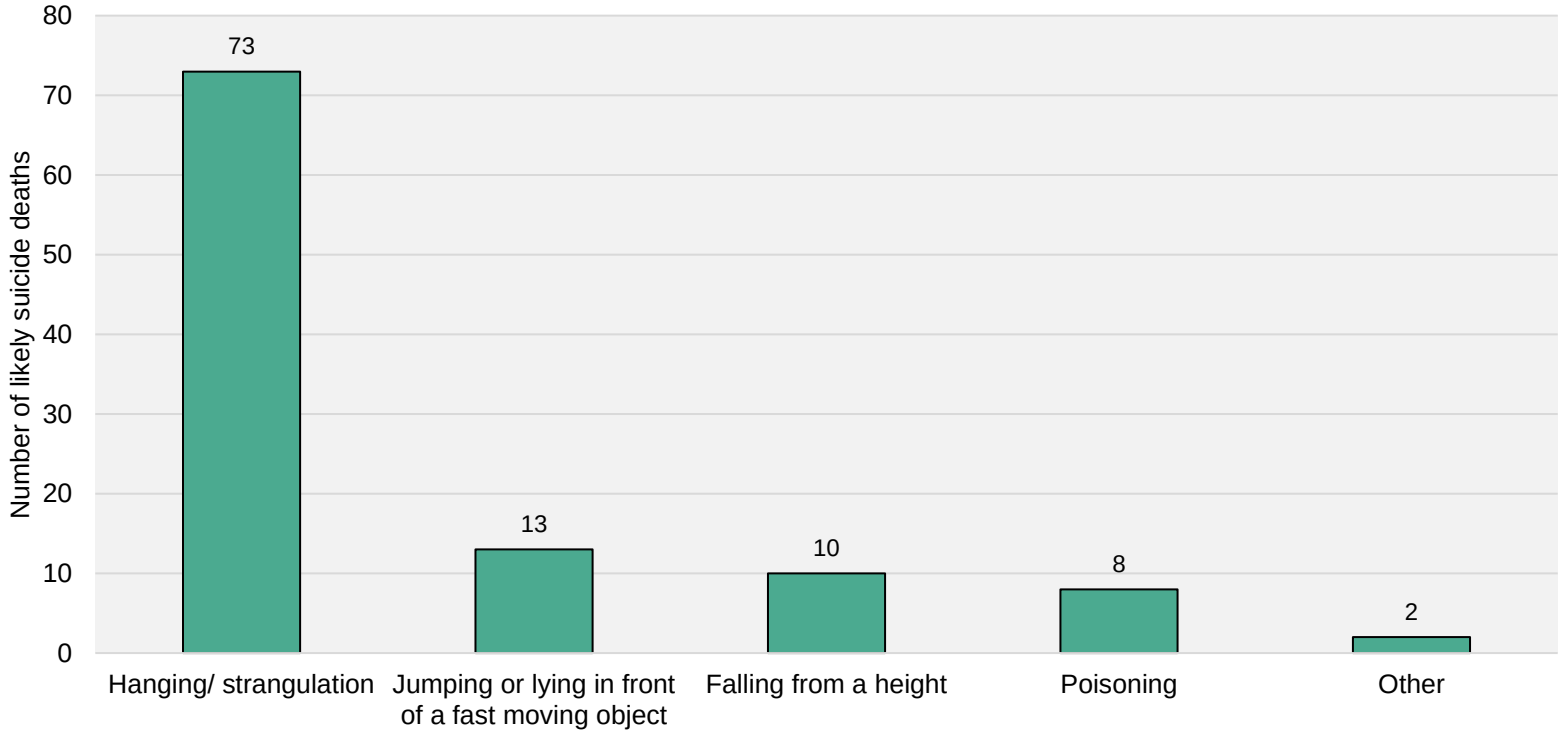
The number of child/young person deaths assessed as highly or moderately likely to be due to suicide by ethnic group, year ending 31 March 2020.



Data source: NCMD

In 22 instances, data for the child's ethnic group was not known or incomplete.

The number of child/young person deaths assessed as highly or moderately likely to be due to suicide by method, year ending 31 March 2020.

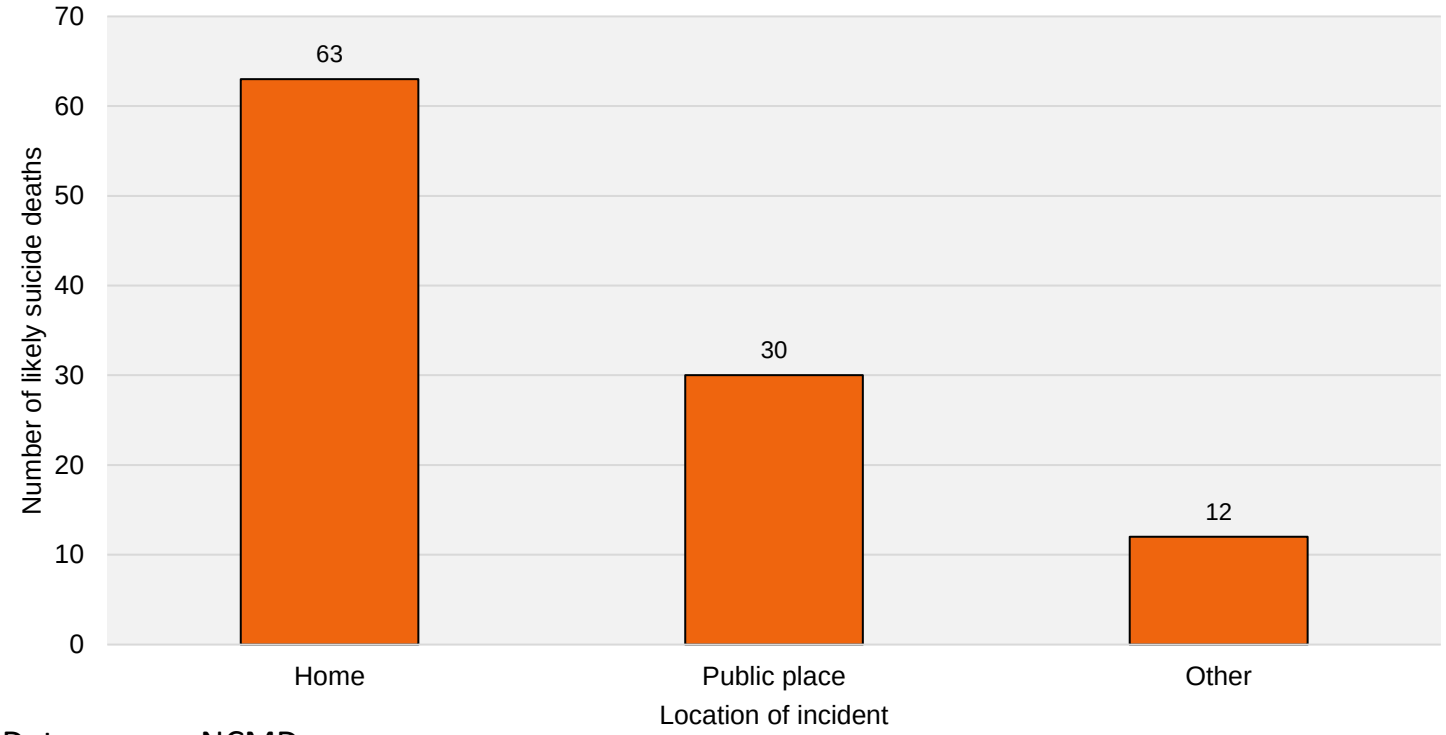


Data source: NCMD

n=106

In 2 instances the method was not known, or incomplete

The number of child/young person deaths assessed as being highly or moderately likely to be due to suicide by the location of incident, year ending 31 March 2020.



Data source: NCMD

In 3 instances the location of the incident was not known or incomplete

Other includes school or college, hospital, other private residences and accommodation

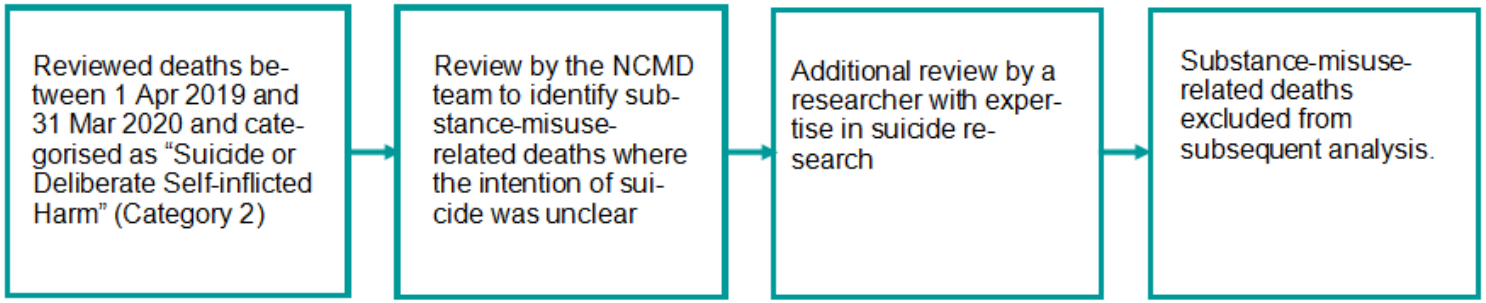
Methodology – Review Cohort

Aim: To analyse the background factors present in those children and young people who died by suicide.

Data Source: Review cohort. From the details provided in the finalised child death review provided by the CDOP. It includes information from the:

- child death notification form
- reporting form
- supplementary reporting form for Suicide or Self-Harm
- analysis form

Inclusion criteria:



Methodology – Review Cohort

The value in analysing this information

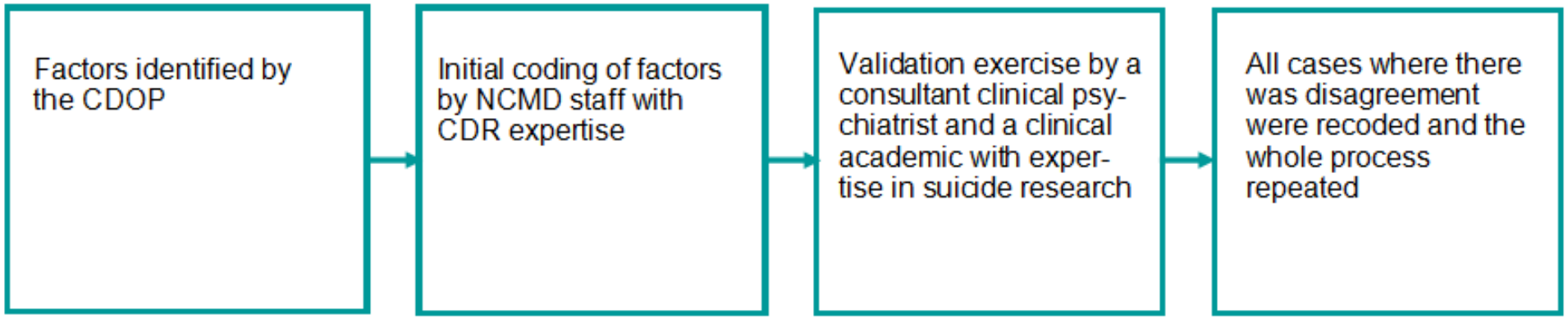
- Identifies features in the background and social context of the child or young person, which may have contributed to their suicide risk

- The data is submitted following the conclusion of the post-mortem and coronial process and the conclusion of the child death review process

- Using the CDOP classification of death enables identification of any deaths not classified as suicide by the coroner, particularly for those deaths that occurred prior to July 2018 when the standard of proof required for a suicide conclusion at a coronial inquest was higher.

Methodology – Review Cohort

Factors analysis



The number of child/young person death reviews with factors present within each category, year ending 31 March 2020.

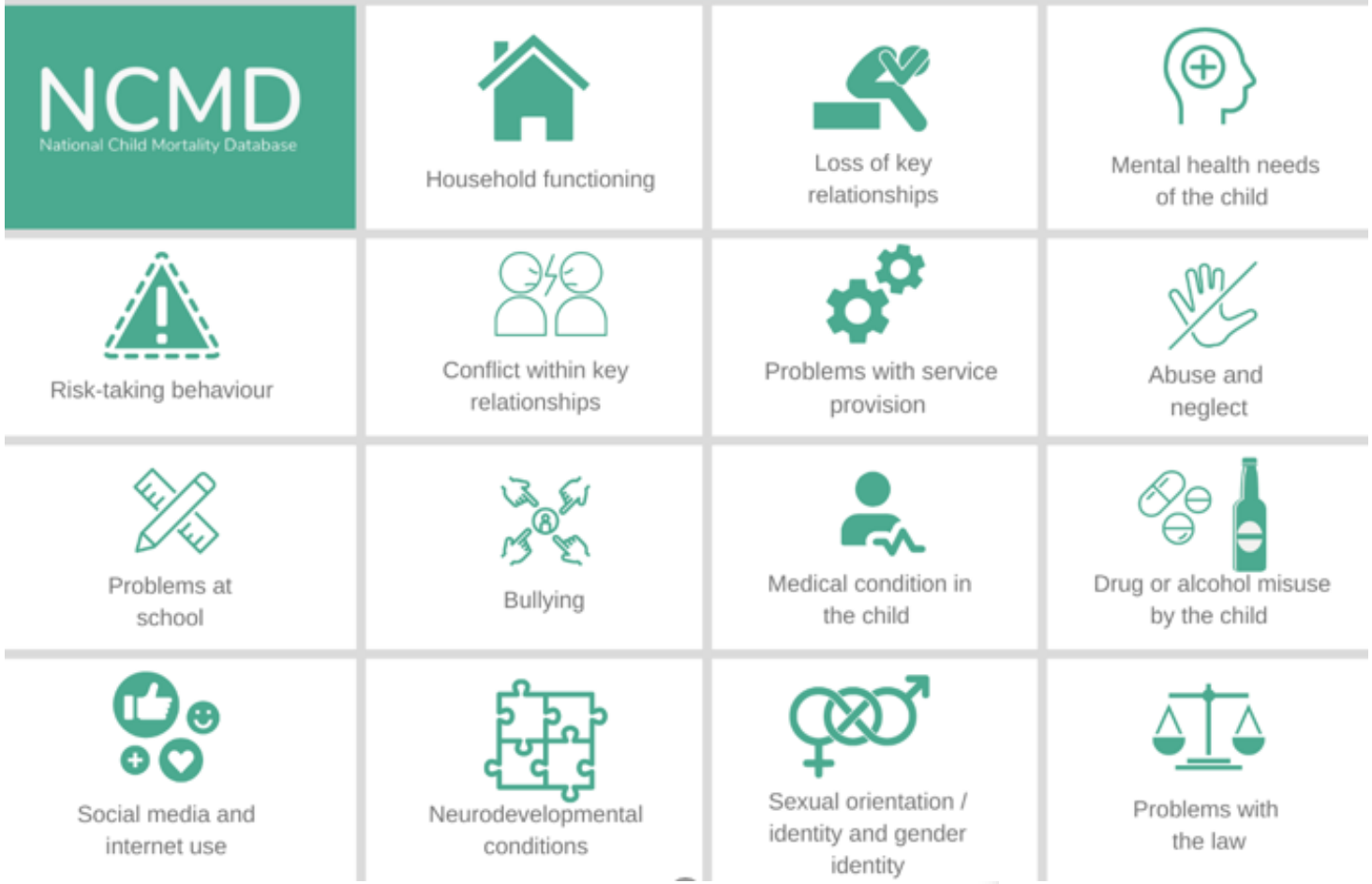
Category	Number (%) of deaths reviewed with at least one factor within the category
Household functioning	63 (69%)
Loss of key relationships	56 (62%)
Mental health needs of the child/young person	50 (55%)
Risk taking behaviours	45 (49%)
Conflict within key relationships	41 (45%)
Problems with service provision	32 (35%)
Abuse and neglect	29 (32%)
Problems at school	27 (30%)
Bullying	21 (23%)
Medical condition in the child/young person	21 (23%)
Drug or alcohol misuse by the child/young person	18 (20%)
Social media and internet use	16 (18%)
Neurodevelopmental conditions	15 (16%)
Sexual orientation, sexual identity, and gender identity	8 (9%)
Problems with the law	8 (9%)

Out of a total of 91 deaths, 81 (89%) children or young people had an adverse factor in more than one category, with 51 (56%) children or young people identifying an adverse factor in 5 or more categories.

The interaction between these factors needs further investigation.

Factors present in suicides reviewed by CDOPs

Based on child death reviews (England) 1 April 2019 to 31 March 2020



The report's recommendations

are based on the data contained in the analysis of the notification and review cohorts and the learning points identified by CDOPs

They are aimed at:

Everyone who is involved in the provision of services for children and young people

We recommend that everyone should:

Study the recommendations relevant to their sector and areas of practice

Take action by utilising quality improvement methodologies in their local area

Do this by working collaboratively across agencies to ensure a systematic approach to improving the safety and effectiveness of their service provision

Recommendations for everyone is involved in the provision of services for children and young people

1. Ensure all frontline staff working with children and young people 10 years of age and over are supported to attend suicide prevention training
2. Improve awareness of the impact of domestic abuse, parental physical and mental health needs and conflict at home
3. Review existing national policies and guidance to ensure they emphasise the range of indicators that this report has identified to improve awareness of the possibility of child suicide
4. Ensure all schools and colleges (including independent and faith-based schools) have clear anti-bullying policies that include guidance on how to assess the risk of suicide for children and young people experiencing bullying and when and under what circumstances multi-agency meetings will be called to discuss individual children/young people
5. Review local policies on information sharing and escalation to ensure children and young people at risk of suicide can be identified and supported
6. Issue revised guidance to schools on the use of exclusion. Guidance should recognise that when a child or young person is permanently excluded from school or college, any relationships with universal services are at risk of becoming fractured
7. Support the continued roll out of children and young people's mental health services across community settings such as schools, local authorities and criminal justice to improve accessibility (including availability of clear referral criteria, pathways and adult service transition) and capacity of services for children and young people.
8. National roll-out of the questions developed in the South-East England Best Practice case study included in this report to ensure appropriate identification and targeting of postvention support (actions taken to support the community after someone dies by suicide)
9. Improve information and advice available to parents/carers, primary care and community services about monitoring (signs to be concerned) and support for children and young people, including those who disengage with mental health services. This should include access to local crisis helplines and national resources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